Ombudsman's Determination

Applicant	Ms S
Scheme	HBOS Final Salary Pension Scheme (**the Scheme**)
Respondents	Willis Towers Watson (**WTW**)
	Lloyds Banking Group (**the Employer**)
	Lloyds Banking Group Pensions Trustees Limited (**the Trustee**)

Complaint Summary

1. Ms S' complaint concerns the Trustee's decision to decline her application for ill health early retirement (**IHER**) while she was an active member of the Scheme.

Summary of the Ombudsman's Determination

2. I do not uphold Ms S' complaint for the reasons set out below in paragraphs 63 to 76 and no further action is required by WTW, the Employer or the Trustee.

Detailed Determination

Material Facts

3. On 4 November 1991, Ms S joined Halifax Building Society (**HBOS**). HBOS was taken over by Lloyds TSB in 2010 and became a division of the Lloyds Banking Group. Ms S remained an employee of HBOS, and, by virtue of her employment, she was a member of the Scheme, which is a final salary arrangement.

4. The Scheme is administered in accordance with the HBOS Final Salary Pension Scheme Consolidated and Conformed Rules, dated 24 May 2006 (**the Rules**).

5. Rule 4.3 sets out the criteria for early payment of a pension under the Scheme. If a member leaves service after reaching age 50[1], but before reaching their normal retirement age (**NRA**) they can claim their pension benefits. However, the pension benefits are actuarially reduced for early payment.

[1] Or age 55, if the member leaves service on or after 6 April 2010.

6. Rule 4.4 provides that an IHER pension may be payable if the member leaves pensionable service because of total or partial incapacity. However, an IHER pension will not be payable if:

> "the member has not accepted an offer of alternative employment from an employer which HBOS considers reasonable; or
>
> …the total or partial incapacity is due to causes within the member's own control."

7. The Rules define partial incapacity as:

> "…physical or mental impairment which, in the opinion of HBOS, appears to be of a permanent nature such that it is unlikely that a Member can follow his or her normal occupation with the Employer and his or her future earnings capacity is seriously impaired. Before HBOS decides whether a Member is suffering from Partial Incapacity, the Trustees must obtain evidence from a registered medical practitioner that the Member is (and will continue to be) incapable of carrying on his or her occupation. HBOS' decision as to whether a Member is suffering from Partial Incapacity will then be final."

8. The Rules define total incapacity as:

> "…physical or mental impairment which, in the opinion of HBOS, permanently prevents a Member from following any gainful employment with the Employer or any other employer. Before HBOS decides whether a Member is suffering from Total Incapacity, the Trustees must obtain evidence from a registered medical practitioner that the Member is (and will continue to be) incapable of carrying on his or her occupation. HBOS' decision as to whether a Member is suffering from Total Incapacity will then be final."

9. If a member, who is in active service under the Scheme, satisfies the criteria for total incapacity, they are entitled to an unreduced IHER pension. The pension is calculated as if their pensionable service included the period between the member's retirement date and their NRA. If the member only meets the criteria for partial incapacity, the IHER pension will not be reduced for early payment. However, for the purposes of calculating the IHER pension, only 50% of the pensionable service they would otherwise have accrued to their NRA is taken into account.

10. Rule 9 contains the options available to a member who has left pensionable service and whose benefits have been preserved in the Scheme. Rule 9.2 provides as follows:

> "If the Trustees agree, a Member entitled to a preserved pension may choose to start receiving it before Normal Retirement Date (but not before age 50 (age 55 if the pension starts on or after 6 April 2010) unless the Member is suffering from Total or Partial Incapacity. If the pension starts before Normal Retirement Date

> however it will be reduced on a basis agreed between HBOS and the Trustees after considering advice from the Actuary.
>
> The Trustees must be reasonably satisfied that the benefits for a Member who retires early are at least equal in value to the benefits that would otherwise have been provided for the Member under the Scheme."

11. In effect, subject to the Trustee's agreement, Rule 9.2 allows a deferred member early access to an actuarially reduced pension before age 55 if the test for either total or partial incapacity is met. These tests are the same for retirement from active status.

12. Ms S was working part-time hours when she commenced sickness absence from July 2015.

13. In or around March 2016, Ms S applied for IHER (**the 2016 Application**).

14. On 22 July 2016, Dr Kennedy, Ms S' Consultant Neurologist, wrote to her General Practitioner (**the GP**). She said:

> "[Ms S] was on sick leave from work since July 2015 and has now unfortunately lost her job altogether as a banking advisor. She is currently applying for a pension on full or partial medical sickness grounds. The requirement for full medical sickness is a permanent condition which would render her unfit to work with no further treatment options that would guarantee a return to work prior to retirement age. For the partial medical sickness category, [Ms S] would be in a position where no treatment is available that would enable her to return to work in the foreseeable future and if she were to return to work it would be in a lower capacity than she was previously. Although chronic migraine is a significantly disabling condition which has a great socio-economic impact due to reduced ability to work I would not be able to say it was a permanent change. We are about to start a new treatment for her chronic migraine which may change the foreseeable future so it does not yet fulfil the partial sickness criteria, but I will be happy to reassess this in the future."

15. A copy of the 2016 Application can no longer be located by WTW, the Employer or the Trustee. However, the Trustee says, based on the limited information that is available, the 2016 Application was declined as Ms S did not meet the partial or total incapacity criteria under the Rules.

16. On 11 August 2016, Ms S accepted voluntary redundancy from the Employer and her Scheme benefits were preserved in the Scheme. To ensure that the redundancy payment she received did not affect her State benefits she made the decision to pay the sum into the Scheme as a one-off contribution.

17. Between August 2016 and December 2016, Ms S contacted the Employer to ask about re-applying for IHER.

18. On 19 December 2016, the Employer wrote to Ms S to acknowledge receipt of her request for a new application for IHER. It explained that as she was now a deferred member of the Scheme, the application had been forwarded on to WTW to consider (**the Second 2016 Application**).

19. Ms S provided the following evidence in connection with the Second 2016 Application (see Appendix):

    - a report dated 17 March 2016, by Dr Stildolph, the GP;
    - reports dated 17 May, 22 July and 21 October 2016, by Dr Kennedy; and
    - a letter dated September 2016, from the Department of Work and Pensions awarding Ms S personal independence payment (**PIP**) for daily living needs from 2 July 2016 to 2 August 2018.

20. On 4 January 2017, WTW wrote to Ms S acknowledging receipt of the Second 2016 Application. It asked whether her medical condition was likely to prevent her from returning to work before her NRA, and for information on treatments she had already undertaken. It also asked for information on any treatment pathways she was due to undergo. WTW explained that the criteria for payment of an IHER, were as follows:

    > "Serious ill-health – This definition is strictly in line with the [HM Revenue & Customs] HMRC definition where the member is expected to live less than 12 months. In this circumstance a one-off lump sum is payable.
    >
    > Ill-health – This definition is in line with the HMRC definition as follows: "A member may take benefits at any age where the scheme administrator accepts qualified medical evidence to the effect that the member satisfies the ill health condition and so is, and will continue to be, medically incapable (either physically or mentally) as a result of injury, sickness, disease or disability of continuing his or her current occupation and as a result of the ill health ceases to carry on the occupation."

21. WTW asked Ms S to complete and return the form of authority, that it had enclosed with the letter, so that it could obtain medical evidence in connection with the Second 2016 Application.

22. On 25 January 2017, WTW followed up on its request for Ms S to complete and return the form of authority so that it could contact her GP to request additional medical evidence.

23. On 17 March 2017, Dr Kennedy wrote to Ms S' GP and said:-

    - Ms S had previously tried the following medication: Amitriptyline; Pizotifen; Propranolol; and Topiramate of up to 100mg twice a day, all of which were ineffective. She currently took 300 mg Gabapentin, which was ineffective, and Naratriptan 2-3 times a month.

- She recently had a third cycle of Botulinum toxin (Botox) administered; this was following a four-year history of chronic migraines. Her last cycle of Botulinum was administered on 21 October 2016. Studies showed that three cycles of Botulinum were more beneficial than two cycles.

- It was unclear whether the Botulinum helped with the severity of her migraines; however, she did report a reduction in the migraines' intensity which had previously worsened over the past two months. This suggested a "wearing off symptoms".

- Ms S was functionally disabled and severely limited by the severity of her migraines, which had prevented her from working since July 2015. She had been asked to complete a medical questionnaire so that Ms S could take IHER, which she fully supported.

- She recommended the use of a supraorbital nerve stimulator and said that there was scope to increase the Gabapentin up to 600mg, three times a day (maximum of 900mg three times a day).

24. The same month, Dr Kennedy submitted a medical questionnaire [2] to WTW. She explained that Ms S suffered from 20 to 25 severely disabling headaches each month. When asked the date Ms S would likely be able to return to her normal occupation, Dr Kennedy said that this was very unlikely. She also said that the type of work Ms S would be expected to do, in the unlikely event of a return to work, would have to be on reduced hours.

25. On 9 May 2017, WTW wrote to Ms S and said that it had received a medical report from her GP in support of her Second 2016 Application. It explained that as her GP may not have been aware of her job role/working pattern, the Trustee may require additional information. WTW asked Ms S to complete the application for early payment of preserved pension and medical authorisation form, that it had enclosed, so that the Scheme appointed medical adviser (**MA**) could review the Second 2016 Application.

26. On 11 September 2017, Dr Gonzalez, the MA appointed to review Ms S' Second 2016 Application[3], issued his report to the Trustee (**the MA's Report**). Dr Gonzalez said that he had considered Dr Kennedy's report of 17 March 2017, the medical questionnaire, and the 2016 Application. Dr Gonzalez said that he did not agree that Ms S met the Scheme's definition of incapacity. Dr Gonzalez said:-

    - In 2016, Ms S' IHER application was declined as it was considered that "further specialist opinion/evaluation of treatment options were required".

[2] Dr Kennedy dated the medical questionnaire 15 March 2015. It appears that this was done in error, as the medical questionnaire was stamped as received on 21 March 2017. Dr Kennedy added the following note: "See attached clinic letter 22/7/16", which postdates 15 March 2015.

[3] Dr Gonzalez previously considered the 2016 Application for IHER from active status.

- Dr Kennedy's report of 17 March 2017 indicated that Ms S had suffered from episodic migraines since 2001; however, they became chronic in 2012. Dr Kennedy's report said that Ms S now suffered from 20-25 migraines a month and experienced mild to moderate headaches on other days.

- Ms S had received a third cycle of Botulinum on 17 March 2017; her prescribed medication was increased to help manage her migraines. Dr Kennedy also mentioned that Ms S might benefit from using a forehead supraorbital nerve stimulator, which was similar to a tens machine.

- Due to the severity of Ms S' migraines, she had been on long-term sick leave since 2015. She was still undergoing treatment with a specialist; however, her previous response to treatments was short-lived or ineffective. The benefit of recent, or ongoing treatments, was yet to be seen. There was still room to increase Ms S' medication.

- Dr Kennedy's medical opinion was that it was very unlikely Ms S would be able to return to her role as a Banking Consultant. However, Ms S might be able to undertake alternative work with reduced capacity/hours.

- Based on the evidence available, there was no clear prognosis that Ms S would be incapacitated up until her NRA. There may be further improvements in Ms S' symptoms which could allow for a return to some form of work.

- Ms S did not meet the incapacity test under the Finance Act 2004[4] (**the 2004 Act**): as she was not incapable of carrying out her normal occupation because of a physical or mental impairment.

27. On 10 November 2017, WTW wrote to Ms S and informed her that the Second 2016 Application had been declined. It explained that, based on the evidence provided, she did not meet the Scheme's definition of incapacity. The evidence did not suggest that with the benefit of future treatment, her condition was likely to be permanent. If she disagreed with the decision she could submit a new IHER application, with new evidence, or she could appeal the initial decision.

28. On 28 November 2017, Ms S emailed WTW and said that she wanted to appeal the decision to decline the Second 2016 Application (**the Appeal**) and explained that:-

    - She trialled Candesartan for her low blood pressure; however, it caused too many side effects leaving her dizzy and disoriented.

[4] The ill-health condition is the minimum requirement set by the Finance Act 2004 for early payment of benefits on health grounds. That is, Schedule 28: "The scheme administrator has received evidence from a registered medical practitioner that the member is (and will continue to be) incapable of carrying on the member's occupation because of physical or mental impairment".

- She had previously trialled Gabapentin which proved ineffective. She was currently taking Rizatriptan; however, she was only allowed to take eight of these a month, when in reality she needed to take eight a day to manage her migraines.
- She was prescribed Buccastem, an anti-sickness medication, to help manage the vomiting side effects of the migraines.
- Her PIP was enhanced to reflect the severity of her condition. She also received employment support allowance (**ESA**) for severe disability.

29. On 29 January 2018, WTW responded to Ms S and said that it had received a response from the Trustee. It was able to accept an Appeal if she provided a GP report based on the contents of her email of 28 November 2017.

30. On 22 March 2018, Ms S forwarded a report dated 27 February 2018 from Dr Kennedy to her GP. Dr Kennedy's report explained that all treatment options for Ms S had now been exhausted. Another cycle of Botulinum was omitted due to a failed response. She was in constant pain and also suffered from nausea on a daily basis, rendering her bedbound. Candesartan and Gabapentin were ineffective, and the Botox injections only provided a few hours of relief overall.

31. On 20 June 2018, WTW wrote to Ms S and said that the Trustee had reviewed the Appeal, along with the newly submitted evidence, and agreed that she met the criteria for IHER. It outlined the IHER options, which were effective from 30 June 2018, and provided the necessary declaration forms for Ms S to complete and return.

32. On 22 August 2018, Ms S telephoned WTW as the IHER retirement figures were 50% lower than the figures provided in a retirement statement in August 2016 (**the August 2016 Statement**). She asked for a breakdown of how her IHER pension benefits had been calculated. The WTW representative explained that the August 2016 Statement showed projected pension benefits as at her NRA. Her IHER pension was payable before her minimum pension age (**MPA**) of 55; so, it had been actuarily reduced for early payment.

33. On 4 January 2019, Ms S emailed WTW and asked if the IHER pension would be backdated to when she first applied for IHER in March 2016.

34. On 11 January 2019, WTW informed Ms S that her IHER pension was only payable from 30 June 2018.

35. On 9 May 2019, Ms S submitted a complaint under stage one of the Scheme's internal dispute resolution procedure (**IDRP**) and said, in summary:-

- She applied for IHER as an active member of the Scheme in March 2016; however, the 2016 Application was declined, and she was eventually made redundant in August 2016.

- She applied for IHER as a deferred member in late 2016. Her application was declined in November 2017. She appealed the decision and was granted an IHER pension from 30 June 2018.

- The IHER pension was half the amount she expected, when compared with the pension quoted in the August 2016 Statement. She believed that this reduction in pension was unjustified as her condition had not changed since March 2016, when she first applied for IHER.

- She should be entitled to receive an unreduced IHER pension.

36. On 5 July 2019, a specified person provided a response under stage one of the IDRP on behalf of the Trustee and said, in summary:-

- They had reviewed all of the correspondence between Ms S and WTW and Ms S and the Trustee. They understood that the 2016 Application was submitted while Ms S was an active Scheme member. The 2016 Application would have been considered by the Employer, as the Trustee was only responsible for reviewing applications from deferred members. So, they would focus on the IHER applications that Ms S made as a deferred member. They would not be considering Ms S' complaint concerning her redundancy and change in status from an active to a deferred member, as these were matters for Ms S and the Employer.

- The earliest date Ms S' IHER pension could theoretically be backdated to was 11 August 2016, the date she was made redundant and became a deferred member of the Scheme.

- The MPA was age 55; pension benefits could be paid earlier through IHER. However, strict eligibility criteria must be met. For example, meeting the definition of incapacity/ill health under the Rules. There were also statutory requirements that needed to be met under the 2004 Act. Both tests required the provision of medical evidence.

- WTW's letter of 10 November 2017 explained that the Second 2016 Application was declined because further treatment options were still being pursued. A key component of the Scheme and statutory IHER tests was the permanence of the incapacity caused by the condition. Dr Kennedy's report dated 17 March 2017 said that there were further treatment options, which could lead to an improvement in her condition.

- The Rules provided that pension benefits paid before a member's NRA, or in Ms S' case before her MPA, would be actuarially reduced. This reduction was intended to offset the cost of the pension being paid over a longer period. If her retirement date had been 11 August 2016, the reduction for early payment would have been greater.

- They were not prepared to make a decision that would effectively reduce the amount of her annual IHER pension. In their view, this would not provide a resolution to her complaint. Additionally, they found no grounds for changing the decision that had been reached by the Trustee.

37. On 9 July 2019, Ms S asked for her complaint to be investigated under stage two of the Scheme's IDRP. She said she was not informed that accepting redundancy could affect the level of her pension benefits from IHER. At the time, she was living on State benefits and had no choice but to accept redundancy and pay it into her pension so that it did not affect her state benefits. Her IHER pension had been reduced substantially whereas her medical condition had not changed since the 2016 Application.

38. On 24 February 2020, the Chair of the Operation Committee (**the Committee**), established by the Trustee, provided its stage two response to Ms S. The Committee's response is summarised below in paragraphs 39 to 49.

The Committee's response

39. While it was correct that the Trustee was not involved in deciding whether Ms S' 2016 Application should be approved, the Trustee and the Employer had since discussed her complaint. Given its complexity, it was agreed that the Trustee would consider the aspects of her complaint about the 2016 Application that related to Ms S' entitlement to pension benefits from the Scheme.

40. The payment of an IHER pension, from active or deferred status, was permitted under the Scheme if the individual met the IHER criteria set out under the Rules. There was also a statutory requirement, known as the ill health condition, which was set out in the 2004 Act.

41. Broadly, the applicable Rules were the same for active and deferred members. Rule 9.2 allowed for the immediate payment of a pension before a member's NRA, with the agreement of the Trustee, provided the member was totally or partially incapacitated. If the IHER pension was being paid from deferred status, there would be no enhancement in pensionable service. Also, the pension benefits would be actuarially reduced if taken before the member's NRA.

42. Rule 4.4 provided that active Scheme members may be eligible for the immediate payment of their pension benefits if they met the definition of either partial, or total incapacity. Both definitions required the medical condition to be permanent.

43. At the time of the 2016 Application, Ms S had been on long-term sick leave since July 2015. From 1991, she had gradually reduced her working week from 35 hours to 16 hours. The evidence available did not indicate that the change in her hours over the years was related to her condition.

44. The MA Report was requested because of concerns about the medical questionnaire completed by Dr Kennedy. While it stated that it was very unlikely Ms S would return

to her role, it also said that reduced hours/capacity might enable a return to employment. The Trustee was unsure whether Dr Kennedy was aware that Ms S was then working part-time (16 hours) and if she was suggesting a further reduction in hours.

45. Dr Kennedy's medical report of February 2018, submitted with the Appeal, made clear that Ms S satisfied the IHER criteria as all treatment options had been exhausted and there had been no significant improvement in her condition.

46. Although Ms S had submitted multiple IHER applications, it was important to note that hindsight did not come into play when reaching a decision about her case. This meant that decisions made in the past should not be reconsidered in light of what was now known about her treatments/condition. The Pensions Ombudsman (**the PO**) had made this clear in a number of Determinations where this had been considered:

> "the fact that the doctor's expectations [of the likelihood of further treatment options improving the member's condition] may have not come to pass is not evidence that the decision was incorrect at the time it was made."[5]
>
> and
>
> "…the fact that expectation of recovery is not realised is not evidence that the decision is incorrect."[6]

47. The Trustee was required to pay benefits in accordance with the Rules; there was no discretion in the matter. Ms S' IHER pension was actuarially reduced as she was below her MPA and a deferred Scheme member. Her IHER pension could not be backdated to the date of the 2016 Application, as she was, at that time, not eligible for IHER.

48. The fact that Ms S satisfied the criteria for an ESA and a PIP was not relevant to the Trustee's consideration and decision on whether she met the criteria for IHER under the Rules.

49. The Trustee understood that Ms S considered that her health condition was the same now, in terms of severity, as it was in 2015 or 2016 when she was an active member of the Scheme. The Trustee also understood that Ms S considered she should have been awarded an IHER pension at that point in time. Nonetheless, the Trustee was satisfied that the correct procedures and analysis were conducted in her case, and that appropriate medical evidence was sought and provided to the MA. The Trustee was also satisfied that the pension benefits awarded to Ms S were at the correct level provided for under the Rules. Ms S did not satisfy the criteria for IHER when she was an active member of the Scheme. This was because treatment options had not been exhausted at that point in time. Furthermore, the permanency of her incapacity, and the impact on her ability to continue in employment, had not been established.

[5] Determination PO-10582.
[6] The former Ombudsman's Determination of Mrs T's complaint [PO-19404].

The Trustee's position

50. Ms S initially applied for IHER in 2016; however, her application was declined, and she ultimately accepted voluntary redundancy from the Employer. The Second 2016 Application was declined on 10 November 2017; however, after receipt of the Appeal, she was granted IHER effective from 30 June 2018.

51. As she was a deferred member, and below her MPA, her IHER pension was 50% lower when compared to the IHER pension that would have been payable had she been granted IHER while an active Scheme member.

52. The key issue that needed to be considered by the Trustee was whether Ms S satisfied the Scheme's criteria for IHER, and the statutory conditions under the 2004 Act, at the time of her IHER applications.

53. Active Scheme members may be entitled to the early payment of their pension if they satisfy the partial incapacity or total incapacity criteria. If either of these criteria are met the applicant will also have satisfied the incapacity test under the 2004 Act. To meet these criteria the medical condition/incapacity has to be permanent. Under the Rules, decisions regarding IHER applications from active members are considered by the Employer. IHER applications from deferred members are considered by the Trustee.

54. To enable the Trustee to carry out the test for incapacity under the Rules, and the statutory test, the Trustee required medical evidence from a registered medical practitioner before a decision could be reached on Ms S' case.

55. Dr Kennedy's report dated 22 July 2016, said that Ms S suffered from chronic headaches; the treatment she had used to date had not been significantly effective. However, it also said that a new treatment was being tried. A report from the Hospital said that:

> "We are about to start a new treatment for [Ms S'] chronic migraine which may change the foreseeable future so it does not yet fulfil the partial medical sickness criteria but will be happy to reassess this in the future."

56. Consequently, the 2016 Application was declined. In regard to the Second 2016 Application, a medical report dated 17 March 2017 indicated that future treatment options could lead to an improvement in Ms S' condition. The dosage on one of her medications had also been increased. Further, the MA Report said that Ms S did not meet the statutory ill health condition, or the criteria under the Rules. Accordingly, the Second 2016 Application was initially declined.

57. Ms S was granted IHER because a new medical report, which was provided with the Appeal, made it clear that all treatment options had been exhausted.

Ms S' position

58. There was no change in her medical condition between the date of the 2016 Application and the date of her Appeal. Given that the Appeal was upheld, and she was granted an IHER pension, it should be backdated to the date of the 2016 Application without any reduction being applied for early payment.

59. Around the time she was made redundant, she entered into discussions with her union representative about the impact accepting redundancy would have on her pension. She was not informed at any time that accepting voluntary redundancy could adversely affect any future entitlement to IHER pension benefits.

60. During these discussions, she was informed that if she appealed the decision not to grant her an IHER pension, and it was overturned, she would be required to repay the redundancy payment, with interest. Furthermore, a IHER pension would be payable at an unreduced rate.

61. She is willing to forfeit any money that she believed was owed to her in the form of IHER pensions payments from when she left HBOS employment. The Trustee should backdate her IHER pension to the date she left employment. Based on her calculations, she would lose £10,000 worth of backdated IHER pension payments. However, she would benefit from receiving an unreduced IHER pension going forward.

62. She is entitled to receive an unreduced IHER pension from the date she initially applied for IHER. She was an active member of the Scheme at the time.

Conclusions

63. It is important to highlight my role at the outset. It is not within my jurisdiction to review the medical evidence and decide whether Ms S should have received an IHER award from active or deferred status. Under the Rules, that decision should be made by either the Employer or the Trustee depending on Ms S' membership status under the Scheme at the time of the application. My role is however to review whether the correct process and tests were addressed.

64. Rule 4.4 provides that if an IHER application is made from active status, the Employer must perform the role of the decision maker. The Employer is required to decide if the member meets the "partial incapacity" or "total incapacity" criteria. Rule 9 provides the criteria for a preserved benefit if a member leaves pensionable service. Rule 9.2 goes on to state that an applicant is eligible to receive the payment of their Scheme benefits before age 55 if they agree that the applicant meets the total or partial incapacity criteria. Both the Employer and the Trustee are required to have taken into consideration the medical opinion of a registered medical practitioner before a decision can be reached on an applicant's incapacity.

65. I should start by referring to Ms S' claim that she should be entitled to an IHER award from active status. There is a distinct lack of information available regarding the 2016 Application. All of the concerned parties, including Ms S, have been approached for

any information on the matter. I have reviewed what information was available or submitted by Ms S following several requests for information on the 2016 Application. Unfortunately, none of these submissions, or the evidence available, contain anything meaningful in regard to the 2016 Application.

66. There is simply not enough information available to review the IHER process undertaken by the Employer in reviewing and declining Ms S' 2016 Application. The little evidence that is available indicates that, at the time, Ms S did not meet the criteria for partial or total incapacity. This is based on the assessment provided by Dr Kennedy via her report of 22 July 2016.

67. Ms S accepted voluntary redundancy in August 2016. Thereafter she was no longer an active member of the Scheme, so she could not be considered for IHER from active status.

68. The IHER payable under Rule 9, on ill-health retirement from deferred status, is limited to an actuarially reduced early retirement pension. In other words, if all conditions were met, Rule 9 entitled Ms S to the early access of her pension before her normal minimum pension age of 55 but it provided no enhancements. Where a pension is actuarially reduced, the earlier the date from which it is paid, the lower the pension and the later the date from which it is paid the higher the pension (i.e. the reduction for early payment will be less if the period to NRA is shorter).

69. The Trustee initially declined Ms S' Second 2016 Application on the basis of the MA's Report. The Trustee accepted Dr Gonzalez's view that, as Ms S was still undergoing/due to undergo treatments, she could recover sufficiently to return to her role or some form of work before her NRA. This was contrary to Dr Kennedy's report of 17 March 2017 that said Ms S was very unlikely to return to her role as a banking consultant. On receipt of the Appeal, the Trustee accepted that Ms S had exhausted all available treatment options and agreed that she was eligible for IHER from 30 June 2018. Ms S has been in receipt of an IHER pension with effect from then.

70. In the circumstances, even if I were to find that the Trustee should have accepted her Second 2016 Application when it was first made and approved immediate payment of an IHER pension at an earlier date, this would only result in her pension being paid at a lower rate with some back-payments of instalments from the earlier date. I also note that, even if Ms S had met the partial or total incapacity criteria at an earlier date, any pension was subject to the Trustee's agreement under Rule 9.2.

71. Nevertheless, I have reviewed the Trustee's handling of Ms S' Second 2016 Application. When considering how a decision has been made by the Trustee, I look at whether:

- the appropriate evidence has been obtained and considered;
- the applicable Rules have been applied correctly; and
- the decision was supported by the available relevant evidence.

72. Providing that the Trustee has acted in accordance with the above principles and within the powers given to it under the Rules, I cannot overturn its decision merely because I might have acted differently. It is not my role to review the medical evidence and come to a decision of my own as to Ms S' eligibility for IHER pension. I am primarily concerned with the decision-making process.

73. I have considered the relevant evidence, including the medical evidence pertaining to Ms S' condition at the time of the Second 2016 Application and the Appeal. I find that the Trustee's decision was based on sufficient information obtained from the MA's Report. The decision was reached on the basis of an apparently competent MA's Report which, in effect, concluded that there was insufficient information to determine that Ms S was permanently incapacitated. I find that the MA's Report did address the right issues. Dr Gonzalez considered the available medical evidence, including Dr Kennedy's report of 17 March 2017 which stated that Ms S was severely disabled and was unlikely to be capable of returning to her former role and would only be able to do so on reduced hours.

74. In noting that Ms S was due to undergo further treatments the results of which were not yet known, it was not obviously wrong for Dr Gonzalez to conclude that Ms S did not meet the criteria for IHER based on the potential outcome of such treatments. While there was insufficient information, according to the MA's Report, to conclude that Ms S was permanently incapacitated, this does not mean the Trustee reached their decision on insufficient information: the Trustee needed to take its decision on the basis of the medical evidence available, and the MA's Report had addressed the right issues and considered the available medical information.

75. As such, I do not find that the Trustee failed to obtain and consider appropriate evidence, failed to apply the Rules or that its decision was not supported by the relevant evidence.

76. The Trustee did uphold the Appeal on the basis of newly obtained medical evidence. The evidence submitted with the Appeal related to the outcome of treatments that Ms S had undergone since the Second 2016 Application. So, the outcome of the Appeal was based on evidence that was not available at the time of the Second 2016 Application. I note that, having been put into payment in June 2018, rather than in November 2017 when the Second 2016 Application was first determined, the pension will have been paid from a later date and will therefore have been reduced less than it would have been if paid from November 2017.

77. I do not uphold Ms S' complaint.

Camila Barry
Deputy Pensions Ombudsman

3 December 2025

Appendix

Extracts from the medical reports submitted with Ms S' Second 2016 Application

Dr Stidolph (General Practitioner) report of 17 March 2016

> "[Ms S] first presented to me with symptoms of classical migraine on the 29/06/2015. At that time, she explained to me she had previously been under neurology, had brain scans and that her current treatment regime of maximum dose of Pizotifen was not working. She was suffering migraines 5 days out of 7 at that time I therefore discussed weaning off the Pizotifen and trying propranolol at a decent does of 80mg daily.
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> Upon review however, 1 month later, her headaches were no better, so I referred her back to neurology. I also issued a sick note as she felt unable to work as her persistent daily headaches were unbearable and affecting her ability to concentrate. She was seen by neurology on 7 November 2015, and an MRI head was ordered. She was also advised to stop all painkillers as this could be contributing to her headaches. She has done this but unfortunately her headaches persist in being constant. The Propranolol was stopped at the end of November 2015 as it was not helping…
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> …
>
> …We discussed how low her mood had become, and her daily migraines persisted to be very troublesome. We discussed management options and decided upon withdrawal from Duloxetine (initially prescribed for stress incontinence but also an antidepressant) and trying Fluoxetine to help with the low mood. I also discussed the use of Topiramate, an anti-epileptic tablet which is recommended by NICE as first line use in migraine prophylaxis.
>
> On 23 February 2016, I reviewed [Ms S] and she was feeling no better but having no side effects from the new medication. I discussed perhaps increasing the Topiramate further and the patient was happy to do so… but also asked the consultant who sees her to consider Botox treatment for her migraines. Botox treatment for migraine is used for severe cases of intractable migraine. Its effect is NOT by paralysing muscles but works in a complex way on the neurovascular function."

Dr G Kennedy's (Consultant Neurologist) report of 17 May 2016

> "…[Ms S] was seen by Dr Hamdalla in November 2015 who initiated Topiramate medication, and [Ms S] was seen by Dr Cleland in March 2016 when the Topiramate dose was increased by 100mg twice daily. [Ms S] has already tried several other agents as listed above with no effect.
>
> …

[Ms S] has also tired a left death ear piercing which has not been helpful but can sometime help if the piercing can flare up. She also finds Naratriptan helpful which she previously overused up to 12 times a month but has now managed to address this and has restricted this down to 2 times a week with no improvement in her headaches. Since the increase in Topiramate up to 100mg twice daily she feels she is struggling with the side effects which include pins and needles in the fingers, loose stools and some weight loss.

…

Opinion

[Ms S] presents in a chronic migraine pattern and has now address her Triptan overuse with no change in the chronicity. It has not responded to several preventative agents and on this basis I agree that she would be eligible for Botulinum toxin treatment. We discussed this in clinic today and will proceed to book her into the next available Botox slot which is Friday 22 July 2016.

In the meantime, as topiramate is now causing intolerable side effects and had not been significantly effective, we agreed to reduce the Topiramate medication down from 100mg twice a day, to 75mg twice daily, 50mg twice daily, 25mg twice daily at weekly intervals before stopping altogether.

In the meantime, she was happy to try an alternative preventative agent, and I have provided a prescription for Gabapentin 100mg 3 time a day for 1 week, 200mg 3 times a day for 1 week followed by 300mh 3 times a day thereafter. This should then be increased up to the highest tolerable effective dose up to 900mg a day maximum.

I have provided headache diaries to complete before her next review to consider Botox treatment if the above medication changes are ineffective."

Dr G Kennedy's report of 22 July 2016

…She has now tired 5 different preventative agents including Gabapentin prescription provided recently up to 300mg three times a day which was ineffective. She has returned to try Botulinum toxin treatment for her chronic migraine.

…

Social history

[Ms S] was on sick leave from work since July 2015 and has now unfortunately lost her job altogether as the banking advisor. She is currently applying for a pension on full or partial medical sickness grounds. The requirement for full medical sickness is a permanent condition which would render her unfit for work with no further treatment options that would guarantee a return to work prior to retirement age. For partial medical sickness category, [Ms S] would be

in a position where no treatment is available that would enable her to return to work in the foreseeable future and if she were to return to work it would be in a lower capacity than she was previously. Although chronic migraine is a significantly disabling condition which has great socio-economic impact due to reduced ability to work I would be unable to say it was a permanent change. We are about to start a new treatment for her chronic migraine which may change the foreseeable future so it does not yet fulfil the partial medical sickness criteria, but I will be happy to reassess this in the future. Despite not fulfilling the formal categories for pension support it must be stressed that the World Health Authority does recognise chronic migraines as a severely disabling condition which has significant impact on the ability to work, and I would predict that [Ms S] would only be able to work in a reduced capacity in the future, if at all.

…

Plan

Headaches diaries have been provided to complete before the next review in approximately 3-4 months' time when we will repeat the set of Botox injections before a full judgement is made on its effectiveness as a treatment

In the meantime, I provided a prescription for zolmitriptan 2.5-5mg orodispersible tablet to see if it is more effective than Naratriptan as a rescue treatment."

Dr G Kennedy's report of 21 October 2016

"…[Ms S] was given her first cycle of Botulinum Toxin treatment on 22 July 2016. Since receiving her treatment, she had severe pstosis to the right eye and to the left eye but less severe. She attended A&E at Sunderland Eye infirmary on the 5 August and there was no treatment given. Ptosis can be a side effect of Botox treatment. She feels her headaches are worse at present and she has had a very poor few months. At baseline she has unremitting daily headache, and her headache diaries show this continued throughout August, September and October with no headache free days. [Ms S] has consented to go ahead with the Botulinum Toxin treatment today in the clinic. We have agreed to miss out the forehead injections to prevent any more drooping of the eye lid. Due to her unremitting daily headache, she is unfit to work at present."